



Mount Clemens Community School District

AUTHORIZATION FOR RELEASE OF STUDENT RECORDS

Last School Attended: _____

Address: _____
Street City Zip

Phone Number: () - Fax Number: () -

Student's Name	Birth Date	Grade

PLEASE MAIL STUDENT RECORDS TO:

Mount Clemens High School
 Attentions: Liz Allen, Counseling Department
 155 Cass Avenue
 Mount Clemens, Michigan 48043
 Phone: (586) 461-3418
 Fax: (586) 469-7058

PLEASE INCLUDE THE FOLLOWING:

- | | |
|----------------------------------|------------------------------|
| _____ Official School Transcript | _____ Immunization Records |
| _____ Test Scores | _____ Birth Certificate |
| _____ Social Security Number | _____ Discipline Information |
| _____ Grades/Report Cards | _____ Current IEPC |
| _____ Grade Placement | _____ Special Education |
| _____ Attendance Records | _____ UIC Number |

Signature of parent/legal Guardian Date

School Personnel Date Sent Date Received

Under the provisions of the Privacy Rights of Parents and Students Act, page 1213, Subpart D, 99.30(b), it is not necessary to have the written consent of the parents or guardians to release records "to officials of other schools or school systems in which the student seeks or intends to enroll."